DOCUMENT RESUME

ED 303 712 CG 021 409

AUTHOR Moriarty, Dick; Chanko, Cathy
TITLE Predisposing, Precipitating, Perpetuating, Professional Help, and Prevention Factors of Eating Disorders.
PUB DATE 17 Nov 88
NOTE 32p.; Paper presented at the Annual Meeting of the Bulimia and Anorexia Nervosa Association (3rd, Essex, Ontario, Canada, November 17, 1988).
PUB TYPE Speeches/Conference Papers (150) -- Reports - Research/Technical (143)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Anorexia Nervosa; *Bulimia; Foreign Countries; *Intervention; *Prevention
IDENTIFIERS Canada

ABSTRACT

This report describes an eating disorder as a multi-dimensional physiological, psychological, social, and cultural illness. A chart describing the typical anorexic and bulimic is included which has on its horizontal axis the predisposing, precipitating, perpetuating, professional help, and prevention factors of anorexia nervosa and bulimia. On its vertical axis, each factor is further divided into physical or physiological contributing factors, psychological or emotional contributing factors, and social and cultural factors. The text of the paper elaborates on the information provided in the chart, examining the physiological, psychological, social and cultural dimensions of eating disorders in the areas of predisposing factors, precipitating factors, perpetuating factors, professional help, and prevention of eating disorders. The need for an accurate diagnosis and appropriate treatment is discussed and the value of family and group support is emphasized. The section on prevention suggests that young people be educated about stress management, physical changes associated with normal development, the side effects of dieting during adolescence, and basic nutrition facts. (NB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED303712

PREDISPOSING, PRECIPITATING, PERPETUATING, PROFESSIONAL HELP, AND PREVENTION FACTORS OF EATING DISORDERS

By Dick Moriarty and Cathy Chanko
BANA-Can/Am
University of Windsor
Windsor, Ontario

Contact: Dr. Dick Moriarty
Director SIR/CAR-BANA
University of Windsor
Windsor, Ontario
N9B 3P4

Area Code (519) 253-4232 ext. 2429

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

✓ This document has been reproduced as received from the person or organization originating it.

Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Dick Moriarty

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

BEST COPY AVAILABLE

Predisposing, Precipitating, Perpetuating, Professional Help and Prevention Factors Eating Disorders

Eating disorders can be described as a multi-dimensional physiological, psychological, social and cultural illness. In this article these four variables are analyzed in terms of the five "P's" listed below:

Predisposing - who is susceptible to succumb to eating disorders.

Precipitating - what incident in a child or young adult's life might trigger a bout with eating disorders.

Perpetuating - how does the addictive nature of eating disorders manifest itself in terms of the development of intervention techniques and coping strategies.

Professional Help - who should be included in the professional team involved in inhospital or outpatient treatment, self-help and support groups.

Prevention - what resources are available in terms of primary and secondary education.

In chart form the physiological, psychological, social and cultural variables are presented for each of the five "P's" of eating disorders.

Note: Include 4 copies of the article

PREDISPOSING, PRECIPITATING, PERPETUATING, PROFESSIONAL HELP AND PREVENTION FACTORS OF EATING DISORDERS

There are a wide variety of factors which contribute to the different stages of eating disorders. To make some order or organization of it, the following chart has been developed on page 2. This chart on the horizontal axis lists the predisposing, precipitating, perpetuating, professional help and prevention factors of anorexia nervosa and bulimia. On the vertical axis each factor is further divided into physical or physiological contributing factors or causes, psychological or emotional contributing factors, and social and cultural causes.

This chart describes the typical anorexic and bulimic. Note that not all the people you encounter with eating disorders will display all of these characteristics and behaviours, and some will display other characteristics that will not be mentioned here. It is important to know that each eating disordered person is firstly an individual and not just like every other eating disordered person.

Beginning with the predisposing factors on the chart, the physical, psychological, social and cultural contributing factors or causes will be elaborated on.

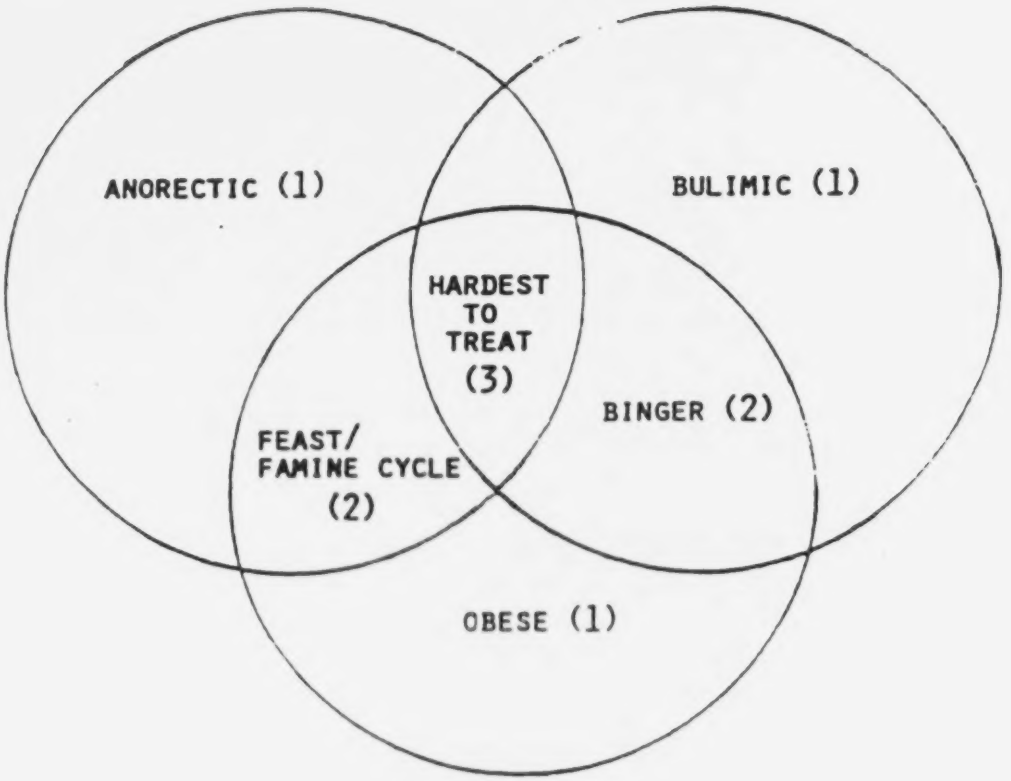
PREDISPOSING FACTORS

Predisposing Factors are those factors that cause a person to have a tendency or susceptibility to acquire an eating disorder (in the future).

Predisposing Factors -- Physical/ Physiological Causes

Overweight - A person who is predisposed toward an eating disorder will more likely be overweight than those not predisposed - remember, this is before the eating disorder is manifested. The potential bulimic is even more likely to be overweight than the potential anorexic.

EATING DISORDERS



EATING DISORDERS

ANOREXIA NERVOSA-BULIMIA

	PREDISPOSING	PRECIPITATING	PERPETUATING	PROFESSIONAL HELP	PREVENTION
PHYSICAL	-GENETIC -OVER WEIGHT -EARLY PUBERTY	-AGE -HORMONAL CHANGE -↓ FOOD INTAKE↑ -↑ ACTIVITY	-WEIGHT CHANGES -↑ ENDORPHIN PRODUCTION	-ACCURATE DIAG. -APPROPRIATE TREATMENT -TEAM APPROACH	-PREPARATION PUBERTY
PSYCHO.	-E.D.I. -ACHIEVER	-"CONTROL" -WITHDRAWAL -GUILT -NEED DENIAL	-DENIES/ADMITS -DISSATISFACTION WITH WEIGHT -SOLUTION → PROBLEM	-UNDERLYING -I.D.E.A.	-ASSERTIVENESS
SOCIAL	-NURTURER	-STRESSFUL EVENT -CHANGE	-PRESSURE	-FAMILY SUPPORT	-STRESS MANAGEMENT
CULTURAL	-SOCIETY VALUES (BEAUTY/ EMOTIONS)	-FOOD VS. EMOTIONS	-CONFUSION	-GROUP SUPPORT	-ACCURATE INFORMATION

EATING DISORDERS

OBESITY

	PREDISPOSING	PRECIPITATING	PERPETUATING	PROFESSIONAL HELP	PREVENTION
PHYSICAL	-GENETIC -NON ATHLETIC	-AGE -HORMONAL CHANGE -FORCED INACTIVITY	-NO OR POOR DIAGNOSIS	-ACCURATE DIAG. & PROPER TREATMENT	-SELF AWARENESS
PSYCHO.	-PASSIVE/ AGGRESSIVE -POOR SELF IMAGE	-STRESSFUL EVENT -ISOLATION	-GUILT -DENIAL -DISTORTION -FEAR	-EMOTIONAL SUPPORT -STRESS COPING SKILLS -TO COPE BETTER WITH EMOTIONS	-SENSE OF CONTROL -STRESS MANAGEMENT
SOCIAL	-AGGRESSIVE PUBLICITY -DIET VS. HEALTHY EATING	-GROUP MEMBERSHIP -LIFESTYLE CHANGE	-PEER PRESSURE -FAD DIETING	-NUTRITION COUNSELLING -ASSERTIVENESS TRAINING	-HEALTH PROMOTION -ASSERTIVENESS
CULTURAL	-FAMILY VALUES -SOCIETY VALUES	-SUPERMOM, SUPERDAD, SUPERKID	-ROLE MODELING -HABITS -SABOTAGE	-BEHAVIOUR MOD. -TIME MANAGEMENT	-RE-ASSESS BELIEFS AND HABITS -GOOD COMMUNICATION SKILLS

Genetic - This refers to the fact that there may be some physiological "X" factor or addiction factor that predisposes a person to addictive behaviour. Eating disorders are considered addictive behaviour by many researchers. So the person who may be susceptible to an eating disorder may have this "X" factor in his/her genes.

In the case of bulimia specifically, there may be a history of obesity, depression, and/or alcoholism present thereby contributing to this person's bulimia in the future.

Early Puberty - Anorexics and bulimics may enter puberty earlier than the normal age range for general society. For example, there was a girl attending one of our programs who entered puberty before any of her friends and she felt very uncomfortable about this. She looked older than most of her classmates (especially the boys), she was much taller, and was much more developed physically. So she started dieting to try to get rid of her new filled-out form and this contributed to her bulimia.

Predisposing Factors - Psychological/ Emotional Causes

EDI - In describing predisposing factors of eating disorders with respect to psychological and emotional causes, the best way to describe this is with the EDI scale. EDI stands for "Eating Disorder Inventory" (Garner and Omstead, 1984). The EDI measures the extent to which a person has an eating disorder. There are eight dimensions or scales to the EDI:

Drive for Thinness - This indicates excessive concern with dieting and preoccupation with weight and pursuit of thinness.

Bulimia - This scale indicates tendency towards episodes of uncontrollable overeating (bingeing) which may be followed by the impulse to purge (vomit).

Body Dissatisfaction - This reflects the extent of belief that parts of the body associated with shape change or increased "fatness" at puberty are too large (hips, thighs, buttocks). So this scale measures to what extent people believe certain body parts are too large.

Ineffectiveness - This dimension indicates the extent of feelings of general inadequacy, insecurity, and worthlessness.

Perfectionism - Perfectionism indicates the extent of excessive personal expectations for perfection.

Interpersonal Distrust - This scale reflects a sense of alienation and a general reluctance to form close relationships.

Interoceptive Awareness - Interoceptive Awareness reflects one's lack of confidence in recognizing and accurately indentifying emotions. For example, a girl may think the emotion "anger" is really "sadness", so she does not know how to react properly to her anger and may keep it inside. This dimension also measures one's lack of ability to know if she is hungry or not.

Maturity Fears - This indicates the extent to which one wishes to retreat to the security of the preadolescent years which is typical of the anorexic.

Achiever - Another point which may predispose a person to have an eating disorder is that the girl is essentially a high achiever - she is a good, quiet, obedient girl who usually does well in school or her job; She is eager to please family and friends. In addition she has the characteristic of being afraid to upset or hurt others' feelings for fear others will not longer like her. Often these type of people derive their worth from what others think of them, not what they inside, think of themselves.

One more point which should be mentioned is that, the girl, before having the eating disorder, perceives she is not controlling her own life. She believes everyone else has contol over her. This is true for bulimics as well as anorexics, expect that bulimics generally feel a bit more in control.

Predisposing Factors - Social-Related Contributing Factors

Overnurturer - The person susceptible to eating disorders may have grown up being a parent to her parent or siblings. She has to take on many responsibilities at a young age, she learns to get her worth out of being a caregiver for everyone else but herself. This also may add to her stress.

Another point under social causes, is that there may have been poor communication patterns in the family in which family members just do not talk about their problems and may live on a superficial level. The North American idea of excellence is not to display our negative emotions but to keep it all inside which is not healthy. Parents may also be overprotective therefore not allowing the child to gain her independence, which will in turn, not build up her confidence level.

Another social-related factor is that the family is overly concerned with dieting, nutrition and fitness. The girl grows up believing these values as very important and tries to adhere to them as best she can.

OR

Possibly one member of the family is seen as obese by the potential anorexic or bulimic (whether she or he is or not) which she equates with gross, and the girl is very fearful she will end up like that, so she constantly watches what she eats to prevent this.

An important point with respect to bulimia is that the girl may have been wrongfully brought up learning that food and drink can bring comfort to you, release your tension. This may contribute to her bulimic activity in the future and cause her to turn to food as an escape.

Predisposing Factors - Cultural Contributing Causes

A very important contributor predisposing a person to an Eating Disorder is that the person takes notice of society's Standards of Beauty.

1. Drive for Thinness - In today's society everybody has to be "Thin to be In", to be accepted, to be beautiful.

2. The Glorification of Youth - All Society wants to remain young or look young because youth is equated with beauty.

3. Fitness/Sports Craze - Now a days, we are all made to feel guilty if we aren't out exercising all the time. There is too much emphasis on exercise and fitness for the goal of losing weight to stay good looking, rather than for the goal of improving our cardiovascular health, and our health in general.

4. Changing Roles for Women - Real women are now expected to be loving, nurturing wives and mothers, and have successful careers at the same time, but this can be very stressful on today's women.

5. Media Stereotypes of Females - Women today are depicted on TV, in magazines, etc., as beautiful only if they are tall, thin, and possess a "perfect" body and "perfect" features.

The potential anorexic or bulimic person sees these ideas as society's Standards of Beauty and tries to emulate them in her life which is very hard, if not impossible in may cases.

PRECIPITATING FACTORS

These are factors that hasten the occurrence of the eating disorder, or trigger or bring about the manifestations (outward physical signs) of it.

Precipitating Factors - Physiological/ Biochemical Causes

Age - Age of onset for anorexia is puberty to about age 22 or 23. The age of onset for bulimia is usually a bit later, but the overall range is from 7 to 70 as far as the people we've seen at BANA, so you can see eating disorders can occur at any age.

Hormonal Changes - The time of hormonal changes is an important physiological factor because girls' bodies are changing and they are filling out more and gaining weight -- more weight than boys of the same age. This can really bother some girls and cause them to start on strict diets.

Food Intake - The food intake will change at this time, for anorexics it will decrease - they will start eating more low-calorie, diet foods and restricting their food choices; and for bulimics, it will increase (mostly when they are eating in private). This is when the bingeing begins. You may notice she is eating larger amounts of food, but not gaining weight as she may also start purging at this time to get rid of the excess food.

Activity - At this time the girl may increase her exercise level and start on some fitness program or become more involved in a diet/fitness program, such as aerobics, as a way of losing weight. This increase in activity is more common for anorexics than for bulimics as anorexics are much more fanatical about staying thin.

Precipitating Factors - Psychological/ Emotional Contributing Factors

"Control" - The anorexic may find it more difficult to make decisions and stress may be building up in her life. So she starts using food as a means of inner control - controlling herself by eating less - now she is the one in control, at least in this aspect of her life. Whereas for the bulimic, she uses food as a means of going out of control because she is always in control in her outside life. She is always nice to everyone, very sociable, putting on a happy face for society.

Withdrawal - The anorexic now has peculiar patterns of eating - she is eating less sociably, cutting her food into small pieces, playing with food. When she does eat, she does not want anyone to see her consuming food, because she believes this to be shameful. She wants to be alone much of the time also because she does not want anyone to interfere with her new rituals and scheduling of daily activities. The bulimic is privately overeating, shameful at how much she consumes. Then she privately gets rid of it. So you may see evidence of vomitting or laxative abuse caused by her purging.

Guilt - Both these types of people now have guilty feelings about eating in general because they are so fearful of gaining weight, and are afraid they cannot stop eating voluntarily.

Need Denial - They substitute overeating or not eating for their true needs in life. They believe they have no needs and should not have needs, because that's selfish and they don't want to be seen as selfish.

Another contributing factor under Psychological/ Emotional is that everything to them is perceived in either black or white, bad or good. You cannot be in-between - these girls can't distinguish the grey areas. Everything they do is perceived as very good or very bad. Either they do exceptional or they are a total failure. These are very hard rules to live by.

Precipitating Factors - Social and Cultural Causes

Stressful Event - A stressful event in the girl's life may trigger the beginning manifestations of the illness. Examples of stressful events are a death or serious illness of a family member, alcoholism or other drug abuse of a family member gets out of hand and creates a lot of tension. Aother example is a parent, teacher or coach may comment on the girl being a bit overweight. Even in a joking manner, young girls may take this very seriously and begin very strict dieting which just goes too far.

Change - A change in the girl's situation or environment can be stressful to her also. Examples are moving to a new neighbourhood or school and leaving old friends behind, having to make new friends. A change of surroundings from the familiarity of before; breaking up with a longtime boyfriend. This can all be very upsetting to her.

Another instance which my trigger the eating disorder is in the case of divorce and the child is separated from one parent - this can be very traumatic. Even if the girl's father leaves on a long business trip, this can be a trigger. For example, there was a girl in one of the summer camps whose father left on a business trip to an Eastern country. Her mother, who usually counted on the father for support now had to rely on the daughter which thereby put pressure on the girl. This is the time she manifested her anorexic symptoms. So a trigger may be a change in the family situation.

OR

The environment stays the same, but the girl changes. For example, when at puberty, there are many changes going on within the girl that may frighten and confuse her, and she may want to retreat to the security of childhood, so she may begin dieting to lose her new figure and extra weight.

Food vs. Emotion - This refers to the anorexic who learns to turn away from food to cope with problems and tension (she does this by withholding food); and the bulimic who turns to food to cope (by bingeing at times that are stressful). So it's a case of food being avoided or abused to deal with emotions.

PERPETUATING FACTORS

Perpetuating factors are those factors that perpetuate or make the eating disorder endure or last, and cause it to continue on, thereby getting worse.

Physical/ Physiological Factors

Weight Change - For the anorexic, a serious point in her illness occurs when she loses 25% of her normal body weight. This is a very serious condition. For the bulimic, if you notice many fluctuations in weight - like her weight going up and down 5 to 10 pounds often, this is serious. However, it should be mentioned that if you do not notice fluctuations, her case can still be seriously health-threatening. So do not keep looking for that condition to determine if she is definitely bulimic and seriously ill because this doesn't always show up in all bulimics.

Endorphin - The anorexic may have a higher than normal endorphin production caused by the self-starvation or binge/purge cycle. This is caused by the release of morphine in the brain. Some marathon runners also experience "endorphine highs". In addition, the anorexic and bulimic may have high cortisol levels which are indicators of depression.

The other symptoms and characteristics are listed on the yellow BANA brochure. There are some additional self-explanatory symptoms that are in your hand-out on this write-up.

Perpetuating Factors - Psychological/ Emotional Contributing Factors

Denial/ Admittance - This means in most all cases, the anorexic will adamantly deny she has a problem. Because of her image distortion of her body, she does not realize how dangerously thin she is. She keeps wanting to lose "just five more pounds" then she will be happy, but in reality, she'll never feel thin enough to stop dieting.

For the bulimic, she is more willing to see and admit that there is a problem, but still may not seek help right away because she is so ashamed. Bulimics are more able to see there is a problem because of the bingeing and purging characteristics. Bulimics feel unnatural and ashamed, whereas the anorexic just thinks she is on a strict diet trying to reach her goal.

Unhappy about Weight - The anorexic is very unhappy about her weight and never feels thin enough. Even in some cases if an anorexic does realize how thin she is, she still wants to lose weight. On the other hand, bulimics may have the same feelings and are unsatisfied with their bodies and weight, but have much less image distortion about their actual weight.

Anorexics will only eat low-calorie food and will restrict their food choices even more as the illness continues. At the BANA Summer Camp, one anorexic would not even drink Diet Tab because it contained one calorie and would not use toothpaste for fear it contained hidden calories. Bulimics also restrict their diets usually except when bingeing, of course. Then they will consume many high-calorie foods such as cake, ice cream because it is easy and quick to get down, and to bring up.

Withdrawal/ Sociable - The anorexic withdraws more than ever at this time - from friends, family. This is because they will interfere with her strict dieting and other behaviours such as her rigid schedules she makes for herself.

The bulimic, on the other hand, is still sociable; however, this is only a facade she is putting on. For example, a girl in one of our programs came across as very outgoing and friendly and she had a very happy disposition in front of everyone. However, she described herself at one time as 'happy on the outside, but crying on the inside'.

It is not uncommon for the bulimic and anorexic to feel depression, hopelessness, and have feelings of suicide.

Solution - Problem - For the anorexic, this is the time when the starvation starts controlling the person, rather than her having control over it. For the bulimic, her binge/purge cycle starts controlling her. This is the time when the solution becomes the problem - that is, the solution they have developed to cope with their problems now becomes the major problem.

Perpetuating Factors - Social and Cultural Contributing Causes

Pressure - She has increasing pressure and stress as others try to make her eat and everyone seems to be against her at this time. She is placing great pressure on herself in her increasing perfectionism in everything.

Confusion - Family and friends are extremely confused at her behaviour and they do not know how to help. Nothing they do seems to help and in some cases, the actions may make the situation worse.

PROFESSIONAL HELP

Professional Help - Physiological/ Physical Factors

Accurate Diagnosis - Hospitalization is necessary for the anorexic whose weight reaches 25% less than normal minimal weight and/or if other complications arise - for example, dehydration and fainting. For the bulimic, hospitalization is necessary if complications occur such as blackouts, dehydration, large electrolyte imbalance, extremely severe cramps, and also for the reason of simply getting her binge/purge behaviour under control. There is also outpatient treatment at the hospital where she comes in once a day for testing, counselling, etc., but does not stay overnight.

Appropriate Treatment - A general medical doctor is teamed with other professionals such as an gastroenterologist, endocrinologist. Also a dietitian is required to monitor weight, provide a nutritious, well-balanced diet, and teaches how to form healthy eating habits. Nurses are others who play a part in providing support for the patient.

The eating disordered individual should be warned that there may be much discomfort at the beginning of treatment in the form of bloating, gas retention, belching, cramps, etc. as she starts eating more normally - but she must be assured that these are normal and temporary.

Sometimes drugs are used such as anti-endorphin and anti-depressant drugs to get the patient to feel more at ease eating and therefore more likely to eat, and to help her feel better in general.

A positive fact to to realize is that almost every system of the body will return to normal functioning with proper treatment.

Professional Help - Psychological/ Emotional Causes

This is the point at which the sick person realizes she has a serious problem and truly wants to help herself. Until this point she may refuse help.

Underlying Issue - A teamwork of professionals try to get at the underlying issue - remember food is only a manifestation of the problem - abusing food is the physical way of showing that there is something wrong emotionally. This is what the psychiatrist, psychologist, nurse, social worker, counsellor all try to get at. It may be beneficial to join a self-help group also as an adjunct to treatment where she can be with others who are going through the same thing.

There is going to be great anxiety in seeing herself gain weight, but she has to be reassured that this anxiety is normal and will eventually pass with counselling.

It will be beneficial for her to learn new coping strategies such as we have at our BANA Summer Camp. Relaxation techniques, dance, music, and art therapy, health/ fitness, cooperative games (as opposed to competitive games) all are used to replace negative food-related behaviour and to provide a social environment and encourage self-confidence in the eating disordered individual.

IDEA - IDEA stands for Identification, Delineation, Evaluation, Action. To every problem you can supply a solution, and the same for eating disorders. You Identify the problem, you Delineate or describe in detail the characteristics, Evaluate how to go about solving it, and Action - where you actually do the solving.

Professional Help - Social and Cultural Factors

Family Support - Family support is extremely important. The patient should know that her family and friends are there to give her support, hope, encouragement and love in helping her recover.

Group Support - A self-help group can be quite helpful, where she can share her problems and feelings and attitudes with others in a relaxed, comfortable setting.

PREVENTION

Physiological/ Biochemical Contributing Factors

Puberty Changes - Young people should be aware of some important facts when they are growing up and their bodies changing. Knowing and understanding these facts may help in preventing an eating disorder in the future.

Young people should know that gaining weight when developing is normal and girls will naturally gain more weight than boys of the same age and will naturally fill out more.

Know that dieting before you have finished growing can stunt growth permanently, and can lead to diseases such as osteoporosis, and other nutrient-deficient diseases. Dieting too much can cause adverse effects to hair, skin, nails, etc.

If you do need to diet, and a medical doctor has recommended you to, know that you should never choose a diet that recommends you consume less than 1200 kcal per day, and never plan on losing more than two pounds per week. If you do not follow these rules, the effects of the dieting will only be short-term.

If you do have to go on a diet, choose one that still follows Canada's Food Guide principles, and ask a dietitian for tips, not one of your school buddies.

Never skip meals to lose weight because it will not work in the long run; form the habit of consuming a well-balanced diet as early as possible.

Know that three meals and two snacks a day are better for weight management than just one or two large meals a day.

Fad diets, diet pills, diuretics, laxatives, vomiting do not help you lose weight, especially in the long run, and in fact can be very dangerous to your health.

Be aware of the physiological "X" factor if it is present in your family history, and know that you may be susceptible to acquire an eating disorder.

Prevention - Psychological/ Emotional Contributing Causes

Assertiveness - As for the Psychological/ Emotional factors in prevention, Assertiveness is a big point. Many people today should learn to speak up more and be assertive - do not hold your anger and emotions inside because this can lead you to manifest your problems in other, more destructive ways. Don't keep emotions bottled up. Possibly take an Assertiveness Training course or read books on Asserting Yourself and Learning to say 'NO' without feeling guilty.

Learn to relax, be selfish once in a while, treat yourself as you would your very best friend. Realize that nobody's perfect and you can never be perfect in everything. Failure is a part of life and you can learn from your mistakes.

Of great importance, learn not to feel guilty if you are a little overweight, stop paying so much attention to those fashion magazines and TV soap operas. These people are not the norm in society. Realize that everyone has his or her natural set-point weight which is very hard to change.

Prevention - Social and Cultural Factors

Accurate Information - learn about basic nutrition facts from a qualified professional - a dietitian, or a recommended nutritionist.

Society should not perpetuate the wrong ideas about food and what part it plays in our lives. Food is not there for comfort or to release tension. Food is fuel for the body.

Elementary and Secondary school programs should include the BANA Preventive Curriculum for Anorexia Nervosa and Bulimia to help prevent eating disorders from occurring in this age group.

Stress Management - We should learn how to deal with stress and tension constructively because there is so much stress in our culture today, especially on young people. Relaxation Therapy, moderate exercising, or a constructively hobby may help in preventing young, and older people from acquiring Eating Disorders.

You can see that there are numerous and varied contributing factors and causes that surround an eating disorder - it is not simply a psychological problem or a physical ailment, but many factors in combination. Hopefully, the information related here has increased your knowledge and insight in the field of eating disorders, and you will be able to put this information to use in the future if you encounter an eating disordered individual.

References

Amber, Neil. (March 19, 1983) Suicide Attempted: Weight obsession problem in sports. Globe and Mail, 55.

Antony,J., Wood, I.K.,& Goldberg,S.C. (1982) Determining the populations at risk for developing anorexia nervosa based on selection of college major. Psychiatry Research, 7, 53-58.

Avener,J. (Nov.,1985) Eating disorders in young athletes. The Physician and Sports Medicine 13, 11, pp.89-106.

Bayder, S. (Nov.,1985) Eating disorders in young athletes. The Physician and Sports Medicine, 13, 11, pp 89-106.

Bemis, K.M. (1978) Current approaches to the etiology and treatment of anorexia nervosa. Psychological Bulletin, 85, 593-617.

Blumenthal,J.A., Rose, S., & Chang,J.L. (1985) Anorexia nervosa and exercise surplications from recent findings. Sports Medicine, 2, pp 237-247.

Brohman, A. (Nov.,1985) Eating disorders in young athletes. The Physician And Sport Medicine, 13,11, pp 89-106.

Bruch, H. (1973) Eating disorders: Obesity, anorexia nervosa, and the person within. Basic Books: New York.

Bruch, H. (1975) Obesity and anorexia nervosa: Psychological aspects. Australian and New Zealand Journal of Psychiatry, 9, 159-161.

Bruch, H. (1978) The golden cage. Cambridge: Harvard University press.

Brumberg,J.J. (1982) Chlorotic girls, 1870-1920: A historical perspective on female adolescence. Child Development, 53, 1468-1477.

Burke, P.N. (March,1978) Nutrition for women athletes: Commonly asked questions. JOPERD, 58, 3, pp 41-45, 50-51.

Campbell, J., Moriarty, D., & Porter,J. (July/August, 1986) Anorexia nervosa. Body dissatisfaction in a high risk population. CAHPER Journal, 52, 4, pp 36-42.

Canada Fitness Survey. (1982) Canada's Fitness: Preliminary findings of the 1981 survey. Ottawa, Ont.

Canadian Youth and Physical Activity. (1983) Ottawa: Fitness and amateur sport.

Carney, B. & Veilleux, M. (French Trans.) (1986) BANA Preventive Curriculum for Anorexia Nervosa and Bulimia. Windsor, Ont.: BANA - Can/Am.

Castagna, K. (1983) Psychological aspects of eating disorders. Audio and TV tape of presentation at the first annual conference of the Can-Am Bulimia and Anorexia Nervosa Association, held at Windsor, Ontario, September 14, 1983.

Crago, M., Yates, A., Beutler, L.E., & Arizmendi, T.G. (1985) Height and weight ratios among female athletes: Are collegiate athletics the precursors to an anorexic syndrome? International Journal of Eating Disorders, 4, 1, 79-87.

Crisp, A.H. (1977) Some psychobiological aspects of adolescent growth and their relevance for the fat/thin syndrome. International Journal of Obesity, 1, 231-238.

Crisp, A.H. (1980) Anorexia nervosa: Let me be. Academic Press: London.

Crisp, A.H. (1981) Anorexia nervosa at normal body weight: The abnormal weight control syndrome. International Journal of Psychiatry in Medicine, 11, 203-233.

Crisp, A.H., Hsu, L.K.G., Harding, B., & Hartshorn, J. (1980) Clinical features of anorexia nervosa: A study of a consecutive series of 102 female patients. Journal of Psychosomatic Research, 24, 179-191.

Crisp, A.H., Palmer,R.L., & Kalucy, R.S. (1976) How common is anorexia nervosa? A prevalence study. British Journal of Psychiatry, 128, 549-554.

Diet High (June, 1983) Self.

Do women start smoking for weight control? Canada Fitness Survey Highlights, No. 20. Ottawa, Ont.

Enright, A.B. (1982) Interview in Windsor, April 15 at L'Auberge.

Feighner, J.P., Robins, E., Guze, S., Woodruff, R., Winokur, G., & Munoz, R. (1972) Diagnostic criteria for use in psychiatric research. Archives of General Psychiatry, 26, 57-63.

Fitness and Aging. (1983) Ottawa: Fitness and Amateur Sport.

Fitness and Lifestyle in Canada. (1983) Ottawa: Fitness and Amateur Sport.

Frisch, R.E. (1983) Fatness and reproduction: delayed menarche and amenorrhea of ballet dancers and college athletes, in Darby, Padraig, Garfinkel,P.E., Garner, D., & Cascina, D.V. Neurology and Neurobiology, Vol. 3. Anorexia nervosa: recent developments in research. New York: Alan R. Liss, Inc.

Garfinkel, P.E., & Garner, D. (1982) Sociocultural Factors, in Anorexia Nervosa: A Multidimensional Perspective. New York: Brunner/Mazel, Publishers: 100-120.

Garfinkel, P.E. (1981) Some recent observations on the pathogenesis of anorexia nervosa. Canadian Journal of Psychiatry, 26, 218-223.

Garner, D., & Olmstead, M.P. (1984) Eating Disorders Manual. Washington, D.C.: A.P.A. Psychological Assessment Resources, Inc.

Garner, D.M. & Garfinkel, P.E. (1978) Socio-cultural factors in anorexia nervosa. The Lancet, 2, 674.

Garner, D.M. & Garfinkel, P.E. (eds.) (1985) Handbook of Psychotherapy for Anorexia Nervosa and Bulimia. New York: Guilford Press.

Garner, D.M., Garfinkel, P.E., Schwartz, D., & Thompson, M. (1980) Cultural expectations of thinness in women. Psychological Reports, 47, 483-491.

Garner, D.M. (1984) Eating disorders and sport/fitness programs, Iona Conference on Alcohol, Drugs and Eating Disorders at the University of Windsor. (proceedings available on audio tape)

Garner, D.M. (1984) Research on eating disorders and sport/fitness participation, Ottawa Cahper, Ottawa, Ontario, Canada. (presentation available on audio tape)

Growe, S.J. (May 9, 1986) The Anorexic Man. Toronto Star, p E1.

Guthrie, S. (1985) The incidence and development of eating disorders within a selected intercollegiate athletic population, unpublished doctoral dissertation proposal, Ohio State University.

Hall, K. (April 7, 1987) Signs of aging can be postponed. Windsor Star, p B1.

Hamilton, M. (1985) Initiation into womanhood: Transpersonal exercises for adolescent girls and women. Unpublished M.Ed. degree, University of Western Ontario.

Hasselbring, B. (Dec., 1986) Are you running too thin? Women's Sports and Fitness, pp 70,72.

Heitzinger, D. (Dec.,1983) Combatting the drug problem without being a policeman. Athletic Director & Coach. Letter 228, p 1.

Hooked on Perfection (Aug/Sept, 1986) Verve, pp 40,42,79,80.

Hope, J. & Bright-See, E. (Nov. 9, 1983) Lean to Extreme Unhealthy, Like Fat. Windsor Star, p E10.

Huenemann, R.L., Shapiro, L.R., Hampton, M.C., & Mitchell, B.W. (1966) A longitudinal study of gross body composition and body conformation and their association with food and activity in a teen-age population. American Journal of Clinical Nutrition, 18, 325-338.

Ideal Weight (Sept., 1983) Vogue, p 706.

Jones, D.L., Fox, M.M., Babigian, H.M., & Hutton, H.E. (1980) Epidemiology of anorexia nervosa in Monroe County, New New York: 1960-1973.

Johnson (Nov. 1986) Female athlete and eating disorders. Athletic Director & Coach, p 4.

Kalucy,R.S., Crisp, A.H., Lacey, J.H. & Harding, B. (1977) Prevalence and prognosis in anorexia nervosa. Australian and New Zealand Journal of Psychiatry, 11, 251-257.

Kendall, R.E., Hall, D.J., Hailey, A., & Babigian, H.M. (1973) The epidemiology of anorexia nervosa. Psychological Medicine, 3, 200-203.

Kluckholn, C. (1954) Mirror for man. New York: McGraw-Hill

Leichner, P. (June,1985) Anorexia Nervosa, Bulimia and Exercise. ANAB, Canada, #4: 1.

Leuson, P., Yarasheski, K.S., & Dolney, D.G. (1984) The Importance of protein for athletes. Sports Medicine,1, pp 474-484.

Marazzie, M.H., Mertz,L, & Leiby, E. (summer, 1986) For want of appetite. Wayne Medicine, 2, 3, pp 3-7.

Moore, K. (1985) Eating disorders in young athletes. The Physician & Sport Medicine, 13,11, pp 89-106.

Moriarty, D. & Moriarty, M. (July/Aug., 1986) Sport/Fitness programs and socio-cultural influences in eating disorders. CAHPER Journal, 52, 4, pp 4-9.

Nylander, I. (1971) The feeling of being fat and dieting in a school population. Acta Socio-Medica Scandanavica, 1, 17-26.

Orbach, S. (1979) Fat is a feminist issue New York: Berkley Books.

People Magazine. (August, 1983) "Sucking Weight" and "Gymnasts Strive Dangerously for the Comaneci Look."

Porter, J., Morrell, T., & Moriarty, D. (July/Aug., 1986) Evaluation of a pilot project for early and pre-adolescents. CAHPER Journal, 52, 4, pp 21-26.

Restak, R. (Aug. 21, 1984) He ran a perfect marathon. The Medical Post, pp 62-64.

Rosenbaum, M. (1970) The changing body image of the adolescent girl. In M. Sugar (Ed.), Female Asolescent Development, pp 234-252.

Schermer, T. (Oct.,1983) Physiological and Psychological Service to University Students, at National Anorexic Aid Society (NAAS) Conference at Columbus, Ohio.

Schiullo, M. (July 17, 1986) Athletes susceptible to eating disorders. Windsor Star, p C5.

Schwartz,D.M., Thompson, M.G. & Johnson, C.L. (1982) Anorexia nervosa and bulimia: The socio-cultural context. International Journal of Eating Disorders, 1, 20-26.

Slager, J.M. (1984) Reversibility of amenorrhea in athletes. Sports Medicine, 1, pp 337-340.

Slavin, J.B. (March, 1987) Eating disorders in athletics. JOPERD, 58, 3, pp 33-36.

Smith, B. (Sat.,Nov. 8, 1986) Food Threatens Skaters Career. Globe & Mail.

Smith, J. (Nov., 1986) Fat Fear Hits Girls Too Early. Windsor Star p C10.

The Little Known Male Anorexic. (May,1983) Psychology Today, p 21.

Theander, S. (1970) Anorexia nervosa: A psychiatric investigation of 94 female patients. Acta Psychiatrica Scandanavica (Suppl.), p 214.

Thompson, M., & Schwartz, D. (1981) Life adjustment of women with anorexia nervosa and anorexia-like behavior. International Journal of Eating Disorders, 2, pp 47-60.

Wrestling without loss. (April, 1983) Science, p 86-87.

Yates, A., Leehey, K., & Shisslak, C.M. (1983) Running - an analogue of anorexia? New England Journal of Medicine, 308, 251-255.

Zimmerman, J. (Nov., 1985) Eating disorders in young athletes. The Physician and Sports Medicine, 13, 11, pp 89-106.

Zucker, P. (Nov., 1985) Eating disorders in young athletes. The Physician and Sports Medicine, 13, 11, pp 89-106.

PREDISPOSING FACTORS

PHYSIOLOGICAL/BIOCHEMICAL

Anorexia Nervosa	Bulimia
- may be mildly overweight before disorder is manifested	- more likely to be overweight than the anorexic (before disease is manifested)
- may be some physiological X factor or addiction factor present	- may be obesity, depression, and alcoholism present
- early puberty	- may also have early puberty, but less likely so than for anorexic

PSYCHOLOGICAL/EMOTIONAL

Anorexia	Bulimia
EDI - Eating Disorder Inventory	
DT - Drive for Thinness-excessive concern with dieting	
B - Bulimia-tendency toward episodes of uncontrollable overeating	
BD - Body Dissatisfaction-parts of body - associated with shape change or increased "fatness" at puberty are too large	
I - Ineffectiveness-feelings of general inadequacy, insecurity, low self-esteem	- similar but more outgoing and sociable at the same time
P - Perfectionism-excelling in schoolwork, extracurricular activities, etc.; great fear of failure; very competitive	
ID - Interpersonal Distrust-general reluctance to form close relationships	
IA - Interoceptive Awareness-unable to recognize and identify one's emotions	
MF - Maturity Fears- wants to retreat to the security of preadolescence; passive, non-assertive	
- good, quiet obedient, eager to please family, friends	
- afraid to upset or hurt others	
- perceives she is not controlling her own life	- feels somewhat more in control

SOCIAL AND CULTURAL

Anorexia	Bulimia
- she takes notice of society's standards of beauty - 1) drive for thinness 2) glorification of youth 3) fitness/sports craze 4) changing roles for women 5) media stereotype of females	
- family is overly concerned with dieting, nutrition/fitness or sports	
OR	
- one member (or more) of family is very overweight - seen as gross	
- The North American idea of excellence is : not to display our emotions - to always remain in control	- do not display negative emotions in particular
- initially middle to upper class social status, but now found in all strata	
- overprotective parents	
- poor communication patterns in family	
- grew up being a parent to the parent - an overnurturer	
	- learned that food/drink can bring comfort, release tension and disappointment as a child.

BEST COPY AVAILABLE

PRECIPITATING FACTORS

PHYSIOLOGICAL/BIOCHEMICAL

Anorexia	Bulimia
- age of onset is puberty to about age 22, however range from age 7 to 70 with large numbers in teens, 20's and 30's	- in general age of onset usually a bit later
- decrease in food intake	- increase in food intake
- starts out on some type of diet/ fitness program and is getting noticeably thinner - reinforced by others	- eats larger amounts of food and does not seem to gain weight.

- dieting, including frequent dieting - when your body has to deal with dieting all the time, your body metabolism changes

PSYCHOLOGICAL/EMOTIONAL

Anorexia	Bulimia
- finds it increasingly difficult to make decisions	
- becomes with body weight; believes she is overweight even when she is not; diets even though she is thin	- becomes obsessed with body weight but sees herweight more realistically than the anorexic
- uses food as a means of inner control - controlling oneself by eating less	- uses food as a means of going out of control (because she is always in control in her outside life)
- peculiar patterns of eating	- eats more in private
- feels guilty about eating	- feels guilty about regular eating and about binges

need-denial - substituting over-eating or not eating for your true needs

- everything is perceived in either black or white, good or bad - can't distinguish the grey areas

SOCIAL AND CULTURAL

Anorexia	Bulimia
- death or serious illness of a family member, close friend	- alcoholism, drug abuse of family member gets out of hand
- situation the same but child changes, as at puberty	
- a move to a new area, new school, new surroundings, particularly elite schools for high achievers - art, dance, academics, athletics	
- divorce - separated from one parent (she may become the "symbol" of the unhappy marriage)	
- parent, teacher, coach comments on girl's weight (overweight)	
- stress building up - unprepared for social and sexual demands	- stress - from job, school, family
- occupation, hobby, interest that involves staying thin (e.g. ballet, fitness activity)	
- sees withholding food as a way of getting attention	
	- may be evidence of vomitting, laxative abuse
- learns to turn <u>away</u> from food to cope	- learns to turn <u>to</u> food to cope
- feels responsible for everyone's problems or sees	- feels responsible to help the world

PHYSIOLOGICAL/BIOCHEMICAL

Anorexia	Bulimia
- loss of at least 15% of normal minimal body weight	- fluctuations in weight, normal or a bit above normal in weight
- higher endorphin production caused by self starvation	
- high cortisol levels is an indicator of depression	
	- periods of blackout or memory loss while bingeing
	- bingeing becomes a wild frenzy when no one's around
- chronic or very frequent constipation	
- electrolyte imbalance	
- terminated or irregular menstrual period	
- tooth enamel deterioration	
- lethargy	
- drinks large amounts of water	- intestinal problems
- dry, scaly skin	- chronic sore throat
- lanugo	- irregular heart beat
- edema - swelling in fingers, ankles, knees	- dehydration
- sensitivity to cold, light	- chipmunk cheeks
- signs of osteoporosis	- dermatitis around mouth
- "drifting off"	- nausea
- insomnia	
- some recover from anorexia nervosa and then become bulimic (about 40%)	
- virtually every system of the body is affected	

PSYCHOLOGICAL/EMOTIONAL

Anorexia	Bulimia
- will only eat low calorie, low fat foods, except when bingeing (restricts diet even more.	
- radical diet swings - binges, fasts, binges, etc.	
- won't admit she has a problem (denial)	- admits there is a problem, but may not seek help
- the attention that she gets because she has gotten control	
- never feels thin enough - "just five more pounds"	
- withdrawal from friends, family - strict dieting interferes with normal activities	- still sociable but is putting on a facade
- spends too much time thinking about food, but will not eat and/or will eat in secrecy	
- after she begins eating, feels she can't stop voluntarily	
- fanatic self-control, discipline	- desire to go out of control - uses food
- may feel depression, hopelessness, suicidal	
- Total burnout - can't concentrate, forgetfulness	
- sexually naive	- often sexually active
- the starvation starts controlling the person	- binge/purge cycle starts controlling the person

" The Solution becomes the Problem "

SOCIAL AND CULTURAL

Anorexia	Bulimia
- friends, family try to make her eat - becomes more stubborn	- friends, family are confused at behaviour, don't know how to help
- she is happy family cannot control this aspect of her life - she continues dieting	- binge is a release - forget about problems, stressed; numbness
- withdrawn from others, anti-social, secretive	- still sociable
	- purging is necessary to relieve the guilt of overeating - continuous cycle

PHYSIOLOGICAL/BIOCHEMICAL

Anorexia	Bulimia
- hospitalization if weight reaches 25% less than normal minimal weight and/or if other complications arise- e.g. dehydration	- hospitalization if complications occur - blackouts, dehydration, great electrolyte change
- outpatient treatment at hospital also - she enters hospital once a day	
- outpatient treatment at hospital also	
- endocrinologist - because hormones off-balance	
dietitian-to monitor weight, nutrient intake, diet, and structure meals and snacks	provide nutritious, balanced
- bedrest	
- slow weight gain, but she realizes there are always relapses	- weight stabilization, but there will be relapses - this is normal
- bloating, gas retention when starting to eat more normally, belching, heart burn, cramps are all normal and temporary	
- anti-endorphin drugs - anti-depressants like "Imipramine"	
- hyperactivity, excess exercise will slow down	
- cessation of strict dieting	- frequency of binging/purging will eventually decrease
- almost every system of the body will return to normal functioning	

PSYCHOLOGICAL/EMOTIONAL

- she realizes she has a serious problem and desperately wants help herself	- knows food is an abusive way of coping and will not work, but she realized the seriousness of her problem before this stage
- has to get at the underlying issue - the food is only a manifestation	
- sees psychiatrist, psychologist, nurse, social worker, counsellor, joins self help group	
- great anxiety in seeing weight gain	
- realizes she is not all alone with her problem - there are others to share it with	
- may learn alternate coping strategies - relaxation techniques, dance therapy, etc.	
- releases pent up emotions	
- feels more in control again, talks of issues other than food and eating	
- learns to love and respect oneself	

Current Treatment Approaches

- Behaviour Modification
- Cognitive
- Psychotherapy
- Family Therapy
- Psychoeducational

} usually some combination of all of the above is most beneficial

---

SOCIAL AND CULTURAL

Anorexia	Bulimia
- family, friends are sympathetic but firm in helping her get better	
- family, friends give her HOPE, SUPPORT, LOVE, ENCOURAGEMENT	

I -Identification

D -Delineation

E -Evaluation

A -Action

PHYSIOLOGICAL/BIOCHEMICAL.

Anorexia

- young people should know that gaining weight when developing is normal and girls will gain more than boys of the same age and will fill out more
- know that dieting before you have finished growing can stunt growth permanently, and can lead to diseases such as osteoporosis
- never choose a diet below 1200 kcal/day and never plan on losing more than 2 pounds/week, this is not healthy
- never skip meals to lose weight - won't work in the long run; form the habit of consuming a balanced diet as early as possible
- know that 3 meals and 2 snacks are better for weight management than one or two meals a day
- Fad Diets do not help you lose weight in the long run; nor diet pills, diuretics, laxatives, and these can even be dangerous - fatal

Bulimia

just

vomitting,

PSYCHOLOGICAL/EMOTIONAL.

Anorexia

- learn not to feel guilty if a little overweight - realize everyone has his/her set weight
- learn to speak up more, be more assertive-you have rights - Take an Assertiveness Training Class
- do not hold you anger inside, emotions inside say what's on your mind
- learn how to relax, treat yourself well
- get the idea of forbidden foods out of your head - all foods are allowed in your diet
- realize that nobody's perfect - you can never be perfect or without fault in everything realize that failure is part of life and you need to experience it and learn from it

Bulimia

3 Types of Prevention

Tertiary - long-established illness
- recognize existence and underlying cause
- diffuse blame.
- confront weight problem
- develop new social and personal self
- self help and support groups.

Secondary - acute stages
- tough love intervention
- professional team approach

Primary - before the problem
- explain set point theory
- educational overview
- association of dieting and eating disorders
- sociocultural factors

SOCIAL AND CULTURAL.

Anorexia

- communicate more within the family
- learn about nutrition from a registered dietitian or a recommended nutritionist. Learn about the harmfulness of repeated dieting
- society should not perpetuate wrong ideas about food and what part it plays in our lives. Utmost, food is fuel for the body .
- teachers, coaches, family should be cautious about telling girls to lose weight as they take these comments very seriously. And young girls should not be pushed to overachieve.
- be aware of the physiological X factor if it is in your family
- society and the media should not portray thin, anorexic models as the norm for beauty, sophistication
- Elementary and Secondary programs should include the EARA Preventive Curriculum for Anorexia Nervosa and Bulimia
- there should be increase advocacy from major professional groups, educators, media, medical/ professional groups, women's rights groups
- learn how to deal with stress constructively - relaxation therapy
  - moderate exercise
  - take a "How to Deal with Stress" class
- as for the current fitness craze, the goal of fitness should be for good health reasons,

Bulimia